# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

**PART I: GENERAL INFORMATION**

| | |
|---|---|
| **Type of Requestor:** (x) HCP ( ) IE ( ) IC | **Response Timely Filed?** (X) Yes ( ) No |
| Requestor's Name and Address<br>Metroplex Diagnostics<br>200 Wynnewood Village<br>Dallas, TX 75224 | MDR Tracking No.: M4-04-3537-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address BOX #: 19<br>American Home Assurance Company | Date of Injury:<br>Employer's Name: SF Holdings Group<br>Insurance Carrier's No.: 149126538 |

**PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)**

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 3/28/03 | 3/28/03 | 95900-26 x 4 | 0 | 0 |
| | | 95904-26 x 6 | 38.40 | 38.40 |
| | | 95935-26 x 6 | 0 | -31.80 |
| | | | | |
| | | | | |
| Total Amount Due | | | | $6.60 |

**PART III: REQUESTOR'S POSITION SUMMARY**

Carrier is disputing the fifth and sixth units of 95904-26. Per TWCC guidelines, sensory nerves are reimbursed per nerve. The documentation supports that six nerves were tested. The carrier did not process the bill according to the way it was billed. They only input four units of 95904-26 when the HCFA clearly shows six units were billed.

**PART IV: RESPONDENT'S POSITION SUMMARY**

All fees were paid according to the MFG. The EOB explains the charge for this procedure exceeds the fee schedule or U&C allowance.

**PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION**

The documentation reports that the sensory tests were conducted on the median, ulnar and radial nerves of both upper extremities. The CPT descriptor for 95904 allows reimbursement per nerve and modifier –26 allow reimbursement at 30% of MAR. The Requestor billed the services using the proper CPT code and applicable modifiers for the professional component and the right and left modifiers. The respondent only allowed reimbursement for 4 of the nerves tested. As three nerves were tested on each upper extremity (6 units), the Requestor is entitled to the additional two units of reimbursement as indicated in the above table.

The Requestor also performed "F" waves to both upper extremities as they are affected by the compensable injury. However, reimbursement is per extremity/unit and only two units are reimbursable in this dispute according to the 1996 MFG Medicine Ground Rules (IV)(B)(2)(b). The Requestor billed and received payment for four extremities/units. In accordance with §413.016 of the Act and Commission Rule 134.800(f), an offset of the amount overpaid will be taken from the total additional reimbursement recommended in this Findings and Decision.

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$6.60.** The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

**Ordered by:**

| | Patti Lanfranco | June 29 2005 |
|---|---|---|
| Authorized Signature | Typed Name | Date of Order |

**PART VIII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P. O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____